

109TH CONGRESS
1ST SESSION

H. R. 3607

To improve the quality of health care through the implementation of computerized provider order entry systems in hospitals and skilled nursing facilities that will result in a reduction in the rate of medication errors and in redundancies and will create more efficiency.

IN THE HOUSE OF REPRESENTATIVES

JULY 28, 2005

Mr. SWEENEY introduced the following bill; which was referred to the
Committee on Energy and Commerce

A BILL

To improve the quality of health care through the implementation of computerized provider order entry systems in hospitals and skilled nursing facilities that will result in a reduction in the rate of medication errors and in redundancies and will create more efficiency.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “The Future of
5 Healthcare—Granting Access to Innovation in America
6 Act (GAIA Act)”.

1 **SEC. 2. FINDINGS.**

2 The Congress finds as follows:

3 (1) Medical errors, such as the miscalculation
4 of prescribed dosage amounts and the illegible hand-
5 writing of physicians, cause many unnecessary
6 deaths in the United States each year.

7 (2) There are 98,000 preventable deaths that
8 occur each year from medication errors in the
9 United States.

10 (3) According to a 2004 Health Grades report
11 on patient safety in American hospitals, medication
12 errors are the 6th leading cause of death among pa-
13 tients in hospitals in the United States.

14 **SEC. 3. IMPLEMENTATION OF COMPUTERIZED PROVIDER**
15 **ORDER ENTRY TECHNOLOGY.**

16 (a) IN GENERAL.—The Secretary of Health and
17 Human Services, in consultation with the Administrator
18 of the Centers for Medicare & Medicaid Services and with
19 the National Health Information Technology Coordinator,
20 may make grants to hospitals and skilled nursing facilities
21 to carry out demonstration projects for the purpose of re-
22 ducing the rate of medication errors and improving the
23 quality of care in the hospitals and skilled nursing facili-
24 ties by installing or upgrading computerized technology
25 that assists in preventing such errors and that increases

1 the quality of care through capabilities such as the fol-
 2 lowing:

3 (1) Providing information on drug-allergy con-
 4 traindications and interactions between drugs.

5 (2) Ensuring that all drug orders are legible.

6 (3) Providing physicians and other clinicians
 7 with a menu of medications, complete with default
 8 doses and a range of potential doses for each medi-
 9 cation.

10 (b) REQUIREMENTS REGARDING DECISION-SUPPORT
 11 SOFTWARE.—

12 (1) IN GENERAL.—With respect to the com-
 13 puter technology described in subsection (a) (re-
 14 ferred to in this section as “CPOE technology”), a
 15 grant may be made under such subsection only if the
 16 applicant involved agrees—

17 (A) for grants made pursuant to sub-
 18 section (l)(2)(A) to ensure that when the CPOE
 19 technology involved becomes operational, the
 20 software described in paragraph (2) has been
 21 installed for use with the CPOE technology; or

22 (B) for a grant made pursuant to sub-
 23 section (l)(2)(B) that is an initial grant referred
 24 to in such subsection, to ensure that such soft-
 25 ware is installed for use with the CPOE tech-

1 nology not later than one year after the receipt
2 of the initial grant under subsection (a).

3 (2) DESCRIPTION OF SOFTWARE.—For pur-
4 poses of paragraph (1), the software described in
5 this paragraph is computer software that assists
6 physicians and clinicians who order prescription
7 drugs and tests in making medication-related deci-
8 sions through functions such as the following:

9 (A) Providing computerized advice regard-
10 ing drug doses, selection, duration, and fre-
11 quencies.

12 (B) Performing drug-allergy checks, drug-
13 laboratory-value checks, and checks on inter-
14 actions between drugs.

15 (C) Providing reminders with respect to
16 corollary orders or drug guidelines.

17 (D) Incorporating patient-specific or
18 pathogen-specific information.

19 (c) REQUIREMENTS REGARDING ELECTRONIC MEDI-
20 CATION ADMINISTRATION RECORD.—

21 (1) IN GENERAL.—A grant may be made under
22 subsection (a) only if the applicant involved agrees—

23 (A) for grants made pursuant to sub-
24 section (l)(2)(A) to ensure that when the CPOE
25 technology involved becomes operational, the

1 software described in paragraph (2) has been
2 installed for use with the CPOE technology; or

3 (B) for a grant made pursuant to sub-
4 section (1)(2)(B) that is an initial grant referred
5 to in such subsection, to ensure that such soft-
6 ware is installed for use with the CPOE tech-
7 nology not later than one year after the receipt
8 of the initial grant under subsection (a).

9 (2) DESCRIPTION OF SOFTWARE.—For pur-
10 poses of paragraph (1), the software described in
11 this paragraph is software providing for an elec-
12 tronic record known as an electronic medication ad-
13 ministration record (also known as EMAR) and is a
14 fully closed-loop medication process that, for the pa-
15 tient involved, electronically documents the specific
16 drug, dosages, routes and times for the administra-
17 tion of medication, and acts as a scheduler by link-
18 ing to a pharmacy information system through a
19 bar-code point-of-care system.

20 (d) CERTAIN USES OF GRANT.—The purposes for
21 which a grant under subsection (a) may be expended in-
22 clude the following:

23 (1) Purchasing and installing CPOE tech-
24 nology.

1 (2) Purchasing and installing decision-support
2 software and EMAR for purposes of subsections (b)
3 and (c).

4 (3) Updating CPOE technology, decision-sup-
5 port software, and EMAR.

6 (4) Training and updating the usage associated
7 with CPOE technology, decision support software,
8 and EMAR with the goal of attaining a 100 percent
9 rate of compliance among physicians and other clini-
10 cians who order prescription drugs and tests.

11 (e) FACILITIES WITH PREVIOUSLY INSTALLED
12 CPOE TECHNOLOGY.—A grant under subsection (a) may
13 be made to a hospital or a skilled nursing facility that
14 installed CPOE technology prior to receiving an initial
15 grant under such subsection. Such a hospital or facility
16 may expend the grant for the purposes described in para-
17 graphs (2) through (4) of subsection (d).

18 (f) MATCHING REQUIREMENT.—

19 (1) IN GENERAL.—A grant may be made under
20 subsection (a) only if the applicant involved agrees
21 that, with respect to the costs to be incurred by the
22 applicant in carrying out the purpose described in
23 such subsection, the applicant will make available
24 non-Federal contributions (in cash or in kind) to-
25 ward such costs in an amount determined by the

1 Secretary. Such contributions may be made directly
2 or through donations from public or private entities.

3 (2) DETERMINATION OF AMOUNT OF NON-FED-
4 ERAL CONTRIBUTION.—Non-Federal contributions
5 required in subsection (a) may be in cash or in kind,
6 fairly evaluated, including equipment or services
7 (and excluding indirect or overhead costs). Amounts
8 provided by the Federal Government, or services as-
9 sisted or subsidized to any significant extent by the
10 Federal Government, may not be included in deter-
11 mining the amount of such non-Federal contribu-
12 tions.

13 (g) REPORTS BY HOSPITALS AND SKILLED NURSING
14 FACILITIES.—A grant may be made under subsection (a)
15 only if the applicant involved agrees that, for each fiscal
16 year for which the grant is made, the applicant will submit
17 to the Secretary, acting through the National Health In-
18 formation Technology Coordinator, a report that provides
19 details on the following:

20 (1) Quantitative reductions in medication er-
21 rors.

22 (2) The level of compliance by physicians, clini-
23 cians, and other staff with respect to the usage of
24 CPOE technology.

1 (3) The difference between administrative and
2 clinical workflows before the implementation of
3 CPOE technology and after the usage of such tech-
4 nology.

5 (4) Alterations and improvements with respect
6 to workflow in the case of facilities that have CPOE
7 technology.

8 (5) An analysis on the improvement of the qual-
9 ity of care and patient satisfaction within the hos-
10 pital or skilled nursing facility involved.

11 (6) The overall economic savings associated
12 with the usage of CPOE technology.

13 (h) APPLICATION.—A grant may be made under sub-
14 section (a) only if an application for the grant is submitted
15 to the Secretary and the application is in such form, is
16 made in such manner, and contains such agreements, as-
17 surances, and information as the Secretary determines to
18 be necessary to carry out this section. The Secretary shall
19 provide technical assistance to hospitals and skilled nurs-
20 ing facilities in the application process.

21 (i) LIMITATION OF GRANT.—A grant under sub-
22 section (a) may not be made in an amount exceeding
23 \$500,000.

24 (j) REPORT TO CONGRESS.—Not later than five years
25 after the initial distribution of grants under subsection

1 (a), the Secretary shall submit to the Congress a report
2 on the progress of the program under such subsection.

3 (k) DEFINITIONS.—For purposes of this Act:

4 (1) The term “barcode point-of-care” means a
5 system that uses bar codes in association with a
6 computer server that interfaces with the admission,
7 discharge, transfer, and pharmacy systems, and with
8 EMAR software, in order to ensure that a patient
9 receives the medications intended for the patient, in-
10 cluding the intended dosages.

11 (2) The term “CPOE technology” has the
12 meaning indicated for such term in subsection
13 (b)(1).

14 (3) The term “decision-support software”
15 means the computer software described in subsection
16 (b)(2).

17 (4) The terms “electronic medication adminis-
18 tration record” and “EMAR” have the meaning in-
19 dicated for such terms in subsection (c)(2).

20 (5) The term “rural hospital” means a hospital
21 located in a rural area, as defined in section
22 1886(d)(2)(D) of the Social Security Act.

23 (6) The term “rural skilled nursing facility”
24 means a skilled nursing facility located in a rural

1 area, as defined in section 413.333 of title 42, Code
2 of Federal Regulations.

3 (7) The term “Secretary” means the Secretary
4 of Health and Human Services.

5 (8) The term “skilled nursing facility” has the
6 meaning indicated for such term in section 1819(a)
7 of the Social Security Act.

8 (l) FUNDING.—

9 (1) AUTHORIZATION OF APPROPRIATION.—For
10 the purpose of carrying out this section, there is au-
11 thorized to be appropriated \$25,000,000 for each of
12 the fiscal years 2006 through 2010.

13 (2) RESERVATION OF AMOUNTS.—Of the
14 amounts appropriated under paragraph (1), the Sec-
15 retary shall reserve amounts in accordance with the
16 following:

17 (A) Fifty percent for grants under section

18 (a) for the initial purchase and installation of
19 CPOE technology and decision-support soft-
20 ware. Amounts reserved under this subpara-
21 graph are not available for hospitals and skilled
22 nursing facilities referred to in subsection (e)
23 and are not available for the purposes described
24 in paragraphs (3) and (4) of subsection (d).

1 (B) Fifty percent for grants under such
2 subsection for upgrading such technology and
3 software and for other purposes authorized in
4 paragraphs (2) through (4) of subsection (d),
5 including initial and subsequent grants under
6 subsection (a) to hospitals and skilled nursing
7 facilities referred to in subsection (e).

8 (C) Twenty percent for grants under such
9 subsection to rural hospitals and rural skilled
10 nursing facilities in the aggregate, which per-
11 centage includes amounts reserved under sub-
12 paragraphs (A) and (B) that are used for
13 grants under subsection (a) to rural hospitals
14 and rural skilled nursing facilities.

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